Implementation Workgroup
Draft Transcript
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Presentation

MacKenzie Robertson – Office of the National Coordinator

Good morning, everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Standards Committees Implementation Workgroup. This is a public call and there will be time for public comment at the end, and the call is also being transcribed so please make sure you identify yourself before speaking. I'll now take roll.

Liz Johnson?

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Liz. Cris Ross? Robert Anthony? Kevin Brady? Anne Castro?

Anne Castro – Blue Cross Blue Shield of South Carolina – Chief Design Architect

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Anne. Simon Cohn? Tim Cromwell? John Derr? Timothy Gutshall? Joe Heyman?

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Joe. David Kates? Tim Morris? Nancy Orvis? Steven Palmer? Wes Rishel?

Wes Rishel – Gartner, Inc.

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Wes. Kenneth Tarkoff? John Travis?

John Travis – Cerner Corp.

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, John. Micky Tripathi? Gary Wietecha? And is there any staff on the line?

Scott Purnell-Saunders – Office of the National Coordinator

Scott Purnell-Saunders, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Scott.

Chris Brancato – Deloitte

Chris Brancato, Deloitte, supporting ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Chris. Okay, Liz, I'll turn it back over to you.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Great. Thanks, everybody, for taking your time in. Again, I think we're making great progress. Today we will go through the inpatient summary and then if we have additional time we'll start on the emergency department summary, but we really are amazingly closing in on getting this work completed in a timely manner.

The other thing I wanted to let the workgroup know is that thank you for all of your help with the letter submission from our group. Really looking at the timing of the final Meaningful Use 2 regulations, via when they have to implemented and so that letter has been completed and will be formally presented to the Standards Group next week, um, with a desire to then present—have the Standards Committee send it on to ONC. So I wanted to let you know that your work has been incorporated to the letter. It's been finalized. It's been reviewed by our chairs and it's been put on the agenda for the next Standards Committee. So again, thank you for that.

And I was—before we get to inpatient, I would ask is there any outstanding business from our outpatient work or anything else that anyone on the call wants to bring up before we start through the inpatient summary?

Okay, well hearing none, Scott, we'll do as we always do. You'll sort of lead us through the conversation and then we will stop and add comments and-and you know, make sure that we get this to, you know, a near ready state because what we hope to do is then go through the emergency room and then do sort of a final check on is everything where we want it for presentation in September to the Standards Committee.

Scott Purnell-Saunders – Office of the National Coordinator

Okay, sounds good. So I'm looking at the, um, inpatient doc—inpatient summary document that we, that was sent out with the rest of the materials this morning. Um, do we want to just start with the comments? Do you just want to try to go through it line by line, as we've done before?

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

No, I don't, I don't think we, and I will ask the group, I don't think we need to talk about why we have test script or what the, um, the second page of this has to do with, you know, what pieces of the meaningful use criterion are we trying to cover. I think we're all familiar with that. I think we'll just start with the scenario assumptions and description itself, Scott, which for the group's purposes would be starting on printed copy page five.

Scott Purnell-Saunders – Office of the National Coordinator

Okay.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

Can I just ask, is anybody having trouble getting online?

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

I didn't, but I don't know about anybody else.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

I'm on, every time I do it I get to something called Adobe Connect.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Huh.

MacKenzie Robertson – Office of the National Coordinator

Yeah, Adobe Connect, if you type, if you select guest and just type your name in that's the webinar platform we use.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

That part I did, and as soon as I do that it says it can't connect and then it goes right to Adobe Connect. All right, I'll give up. I'll try and find the printed document. Thanks.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Caitlin, can you send Wes the inpatient summary document or Scott can you?

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

This is Joe, Joe Heyman. Could you send it to me?

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Yes, for inpatient?

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

Yes.

Scott Purnell-Saunders – Office of the National Coordinator

Yeah, I'll send I'll send the copies of everything that are going to be sent out in 30 seconds or so. I have an e-mail already drafted up.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Okay. So I think the very first comment then, Scott, we was from Joe and I have a kind of a different comment. And I think, you know, one of my questions to you was, you picked critical access and I wondered why that in lieu of an inpatient acute? I mean was there a reason or was it ju—I couldn't figure it out.

Scott Purnell-Saunders – Office of the National Coordinator

I think it was just—I mean it's, um, I don't, I mean I think we just picked a setting. Chris, did you have any specific reason why?

Chris Brancato – Deloitte

No, but again, we, we just picked the setting, and, you know, I certainly do understand the nuances of a CAH and-and, you know, what they do and do not bring to the scenario. So, if you're suggesting we use just—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Yeah, just acute, and, Joe, I would look for your input too, but I would just call an acute inpatient care setting, you know, a hospital acute care a-and that way we don't run into the nuances around critical access.

Chris Brancato – Deloitte

That works for us, no problem. We'll make that change.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

Speaking as someone who's not familiar with the nuances, I imagine that most of the nuances relate to the services that aren't typically provided in a CAH. Are there any services that are typically provided in Community Access that aren't provided in a, in a normal acute care hospital?

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Not to my knowledge.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

Okay, that's fine.

John Travis – Cerner Corp.

Yeah, they face a little more, this is John, they face a little more minimal set, but they are required services that are—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Right.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

Yes, but-so any, any, the assumption is any, all systems must qualify for both, which means if they qualify for acute care hospital then they're automatically qualified for CAH because it's less, it's strictly a subset of the requirement.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

I think that-that's an appropriate characterization.

John Travis – Cerner Corp.

I think most of the difference is going to be on how they are paid.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Exactly right, John. Yep. Okay, um, so and, you know, given that, then wh-that kind of eliminates our issue around hospital …

Chris Brancato – Deloitte

Yes. This is Chris Brancato, yes.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Yes, okay great. Okay, so then, um, if we go then, you know, this is just basically kind of getting the person into the hospital and saying that the scenario would include administrative people, non-licensed clinical, knowing that some of you don't have this yet, and eligible licensed, um, oh pardon me, licensed eligible providers.

So then they go into a typical general medicine unit and you've talked about a workflow, which is rational. Um, the first thing, um, that I came to then, um, is that on page six at the bottom, the way you describe the admission scenario is you have a patient coming in under a primary care physician. It could be under—a primary care physician could be transferring that care to a hospital or caring for the patient themselves, but, um, you give a list of information that you believe is going to be supplied at the point of admission from our, from our doctors and, um, I-I do not believe that to be the case.

Joe, I know that you're exceptional and that you probably provide all this stuff, but this is not realistic in in an inpatient acute care setting on a daily basis.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

I-I'm afraid that—I know I can't see the document where I am.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Okay. So what is listed here is, um, the provider, which would be the primary care physician in this scenario, would provide past medical history, general history, including smoking status, family history implantable external devices, active medication list, past medication history, known allergies, consents, power of attorney and advanced directives.

Chris Brancato – Deloitte

Liz, it's Chris Brancato. So I made some assumptions with that point, and-and being-being in the field I-I absolutely agree with what you say. This was, um, me going back to the rules and the tenants of meaningful use and hoping and, um, you know, in some not too distant future that the, um, attending physician or the physician that referred would have the ability to provide this information from his EHR, his or her EHR. So if that's too far in the future, let me know.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Yeah, I mean, yeah, I think, Chris you're absolutely 100%. This is exactly what we want, and-and it's absolutely the intent and vision of the-of what we're doing. But I think when we build the scenario predicated on this assumption, I don't know what, I'm not going to make up a percent, I mean Wes would probably come closer to knowing a percent than I would, but I-I do-do not think this is anywhere close to mainstream. And so the reason I bring it up is because then we've predicated a number of steps that follow based on the fact that we have this information and we don't.

Wes Rishel – Gartner, Inc.

Um, this is Wes. I've got two procedural questions and then a comment. Uh, are we working on version 1.0 of this document August 9th?

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

We are working on 1.1, I believe. Isn't that right? That's what I have Scott.

Scott Purnell-Saunders – Office of the National Coordinator

It's ver-it's version 1.1 in the update—

Wes Rishel – Gartner, Inc.

Scott, if you could send me that I'd appreciate it. ….

Scott Purnell-Saunders – Office of the National Coordinator

It should be to you right now.

Wes Rishel – Gartner, Inc.

Yeah, and then what I'd, w-w-what I'd like to know is where we are in the document what page number, section number or something.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Okay, so we're under admission scenario. It follows a section called "Workflow" that Scott … that say, "Admission, evaluation, diagnosis and treatment and discharge" on the printed documents on page six. I don't, I don't have the electronic document up.

Wes Rishel – Gartner, Inc.

Okay, so that's good enough. So, um—

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

Could you send it to Joe, too, please?

Scott Purnell-Saunders – Office of the National Coordinator

Yeah, they were sent to the whole e-mail list.

Wes Rishel – Gartner, Inc.

Just now?

Scott Purnell-Saunders – Office of the National Coordinator

Yes.

Wes Rishel – Gartner, Inc.

Okay. So my comment is that there are, um, w-w-what we're trying to test, in my view, is the ability of an EHR in, you know, in … here to-to perform under the new scenario. So to say we aren't going to test it because it won't be done much would leave us in the, in the mode of saying, "Well, we could end up with some places ready to send the information," but the EHR is saying, "Hey, we don't, we don't do that. That wasn't part of the certification."

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

That's a good point, but Chris uh, or John, do you believe that the regs require that the provider provide this information to us in an electronic format?

John Travis – Cerner Corp.

No. I, you know, and I-I'll give an example, this is John, um, that I, that kind of jumped out at me and that was a list of implantable devices. There's not a single reference in the proposed certification criteria to recording an implantable device. Um, you know, so it-it goes out—it's not to say it isn't—

Wes Rishel – Gartner, Inc.

Okay, I'm-I'm-I'm fine with that under that circumstance.

John Travis – Cerner Corp.

Yeah, that-that would be mine—and I'm putting on a narrow lens of, you know, where else might this be used? I think most of the rest of the information on there has got a grounding to be in the list, to be honest, given what—if you go look at the list of information in the clinical summary expected to be there later or the things you'd expect to be collected from the patient, certainly, you know, um, known drug allergies—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

100% that-that was—I 100% agree with you in this administrative scenario. I'll bring those things up. My concern was we sort of, we sort of opened the door to the scenario with saying all of this information will be provided by the provider. I agree with Wes and you, John, both. There should be a, I will just call it a catcher's mitt, for the data to be used if it's available. I'm not sure that and maybe we can test for that, in fact I know we can test for that, if appropriate, but I think you'll pick it up through the scenario.

John Travis – Cerner Corp.

Yeah, I think it-it's very good to ground it in what else might we go do with that. So collection of past medication history sets up certain things. Documentation of allergies sets up other things. And we-we do need a boundary statement of that kind. It is going to have utility for other things as we go through the scenario.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

Well, this is Joe, this is the problem with the current CCR or CDA; that it doesn't include this information.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Right. And so what we need to do Joe and Wes and John and o-other committee members is we need to continue to raise our voice to say, you know, "Begin to include these things because they could, um, very possibly impact the care of the patient in any scenario in which we provide care." Recognizing that to put it in a testing scenario when it's not required is to ask vendors to prove they can do something, which is not required, which puts us in a very difficult—

Wes Rishel – Gartner, Inc.

Well yeah, and-a, and if fact the new, the CDA version also doesn't include implantable devices then, um, there's a lot of pre-work that has to go in order to-to include it and a lot of implementation work once the standards work is done. So I would suggest we keep a list of items to go in a side letter effectively suggesting that the Policy Committee consider them for stage 3.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

There you go.

John Travis – Cerner Corp.

Yeah, it's a very fair comment. I know there's a lot of discussion about devices.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

This is Joe. This first bullet, the only thing that's in a CDA is the problem list, period.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Right.

John Travis – Cerner Corp.

You know, you wonder, um, and this-this is, this could be stretched I'm sure. This is John again. You know, some of the treatments or surgeries could be represented as procedures. So—

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

Well, they-they wouldn't be procedures in most DMRs. Most DMRs separate surgeries from procedures; at least mine does.

John Travis – Cerner Corp.

Fair. I think that that was something that was—I know in dealing with our clients in stage 1 use they were horribly confused by what's a procedure, and looking desperately for a definition of it.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

And then the second, the second, the second bullet, the only thing that's included in a health history within a CDA is the smoking status I assume, and I don't even know if that's in a CDA.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

I don't re—I don't remember it. John, do you? I'd have to go look.

John Travis – Cerner Corp.

I've got the, I've got the, um, summary of care records certification criteria up and admittedly that's not the CDA itself, but it's got all of the referenced standards for the content and, um, aside from smoking status type there's no structured code set standard reference. And I-I'm remembering there's a content list as well. If you'll give me a moment I'll—I mean they-they've got a lot of information that they're suggesting be in it, um, but not all of them have structure.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

You know what we might want to do? I think Wes' idea is really good. Once we get the meaningful use standards, which should be in the next surely 30 days, 45 days, um, the, um, then let's go back and revisit this concept. Um, and the reason I say that to you as a group is that would give us an opportunity to actually see what-where they landed. And then I agree with Wes. Then that gives us a foundation, sort of a launching pad to then say, "As you consider stage 3, here's what's still missing."

Is that acceptable to the group?

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

Yeah, and I would actually look back at all these bullets and see what …

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Exactly.

John Travis – Cerner Corp.

I think that's certainly fair.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

Because almost everything listed here is not in the current summary.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

So given, yeah, so given that, um, you know, w-where we are during this discussion, is it better phrased to simply say, um, "The provider," uh, "has prov-the provider has provided," um, "the following information to the hospital." It-it doesn't, first of all, again, I don't think, do we say as available? What do we do about that? Because like I say you start your whole scenario and if I were—John, you're going to be testing. How would you respond to this?

John Travis – Cerner Corp.

Well, statements like, "It's available," don't do me any good.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Yeah, you have to do it. I know.

John Travis – Cerner Corp.

They're good from a use perspective and I could see that as a, you know, a-a-a manner by which you'd define a use measurement criteria like CMS did for the minimum content they required for a patient electronic copy and if you didn't provide that content you didn't get credit … .

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

… for everything.

John Travis – Cerner Corp.

I think in this case we've—the list does actually need to reasonably test the capability that the EHR's expected to meet. And I'll point you th-in the certification criteria proposed rule, ONC a-asks the question under the clini-the transition of care summary, "Is the EHR technology capable of electronically providing a sufficient amount of a patient's health history using summary of care records formatted using consolidate CDA?"

So they are very much asking for that input, and I imagine through public comment they're going to get a lot and we will—or have gotten a lot—and we will see, um, what may work to be a reasonable list and should ground this in that. You're going, they're going to define what structure, where structure is required, um, because that's definitely a point and that kind of sets a minimum content expectation, as well. And then they'll have other things that might allow for non-structured.

So to address to this point of not much of the health history has got, is documented, I might say it a different way. Not much of the health history is recorded with structure in terms of a standard, other than smoking status, and I don't see in the proposed list that there's, you know—so for example, there's no structure to substance abuse or, you know, psychosocial evaluation or, you know, what's your family history for different kinds of behavioral health issues or substance abuse issues.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Right. Joe?

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

So this is Joe. I would suggest where it says, "The provider has provided," which is kind of a funny thing to say, um, I would suggest they can just say, "The specific document that you want the provider to have provided." So if it's a CDA or if it's a CDA or an official health summary or something like that, I would say that rather than trying to list what's supposed to be in it.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

We could do that and then, um, either Scott or w-w-what we could do is we could then, when we get final regs, we could delineate a little further just for testing purposes.

John Travis – Cerner Corp.

You know, that's a great idea because the work will have been done for you. And what I mean by that is the certification criterion's gonna say what's in it and point to that. If you expect the CD-consolidated CDA to be what is incorporated, then that is the objective you're testing by the step, or I should the criterion you're testing by the step, and there will be an elaborated dataset that'll define what it is.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Exactly. So let's capture—

Wes Rishel – Gartner, Inc.

J-John-John just did the great thing of agreeing with you and saying something different. So, you know, a master diplomat. Uh, but-but I want to be sure that we agree on a principle. Uh, when we're done with this process we will, we will say specifically what data must be extracted from the CCDA as a certification crit-as-as a, in a testing scenario because, because we've had a long series of issues of yeah, we can accept a document but we can't do anything with it.

John Travis – Cerner Corp.

And-and, Wes, you raise something very good. This is John again. If I recall, and I was looking for it and I don't want to take the time today, but in the certification criteria as they proposed it they kind of said in the narrative, they gave a long list of stuff. Not everything neces—and then they made some statements about in a structured format but they didn't say what of the long list of stuff needed to be structured for that incorporation.

Wes Rishel – Gartner, Inc.

Well I-I think there's an issue of a structure that I think you have to go back uh-uh, yeah, there's definitely an issue that there may not be sufficient detail in the specification and it may not be reasonable to accept EHRs to have recorded family history, for example, in a structured format. Um, but, an-and I-I would say we want to just note where our structure is clearly required a-an-and where it's not, but more important, the-the actual criterion and proposed rule was not that you accept the CCDA. It was that you accept any document type out of the CCDA, and be able to extract these data elements from it.

Now extracting a data element doesn't necessarily mean it's structured. So you could be extracting a string of text that describes the family history of cancer uh, but-but the point is you can find that in a document with a computer. Uh, you know, it's a double bonus is you can find it in a way that's structured and you have a system that's able to compute something based on structured data that said the father had prostate cancer or something.

But-but the uh, even if you don't I-I- think following the-the general approach of the proposed regulation, which is you accept all documents in the suite or a list of documents in the suite, I forget which, and you must be able to extract these specific data elements out. I think following that in the testing procedures makes a lot of sense.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

So, Chris and-and Scott we've just thrown a lot of stuff at you. Um, do you feel comfortable that you can translate this into a comment beside these sections, because we know we have additional work to do once we see the final regs for this to be a testable criterion and a-a script that actually does, and that we are then keeping this list so that if things are admitted from the final meaningful use stage 2 that we can put it on our list to then suggest to Policy that they be considered for stage 3?

Chris Brancato – Deloitte

So this is Chris. I-I took copious notes and we will reference the transcript back just to make sure that we captured everything, um, correctly. So the answer's yes, confidently yes.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

And-and we-we'll review. I mean the thing is that we recognize the sooner we get to the document that we will need to do a final review once there's some sort of translating a lot of-of comments into some articulated statements and then we can verify for you next time that we're on track.

M

And I, and I love your unfounded confidence that I actually spoke clearly.

Scott Purnell-Saunders – Office of the National Coordinator

Yeah, I mean we-we-we certainly will go back and check the transcripts, but we'll also try and include as best we can for final review.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Thank you.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

I-I would just like to point out for reality purposes that the one thing that's in here is a statement from the physician about why the patient needs to be hospitalized, which of course would have been the most important part of all of this and much more important than anything in any of the bullets.

M

Indeed.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

We can add that, so the statement of reason for hospitalization. Alright, we're going to go to the next sentence which says, "The information is carried with the patient until they are admitted to the nursing unit."

For the purposes of what we're trying to do I-I would prefer that we say something around, and I don't, so, John, I'm going to turn to you as our vendor partner on this call. Um, you know, I envision this information being available electronically. Not the patient carrying it. I know it's a nit-pick and I don't know if—I, the only thing I care about one way or the other is when this represents a scenario that people would buy into and, but that it doesn't create a testing issue for you.

John Travis – Cerner Corp.

You know it, I have this mental image, this is John, that they've thrown a clipboard onto the bed that they're transporting the patient with. So I'm not so sure that statement adds any value. The next statement really is the meaningful one.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Right, right, 'cause I was going to suggest to you, Scott, we could really just omit this statement if-if nothing else.

Scott Purnell-Saunders – Office of the National Coordinator

No problem.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Okay.

John Travis – Cerner Corp.

Now I'm—this is John again. I do kind of get into the next couple of paragraphs. There's a fundamental question. What do they say about the role of an ADT system or registration system as certified EHR technology? There is not necessarily any predication of assumption that that's in scope, but there's an awful lot going on here that is extraneous, I think, to the scope of certified EHR technology.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

But I'll tell you what is included, John, and this is the reason that we-we've made the choice at Tenet to have proprietary ADT system certified, which is a real pain, but the reason we did it is the regs as previously written stated that where-wherever the source of truth was for this information, where the amendments would take place, had to be certified.

Those on the phone know we use Sonar as our base system and we do run Sonar ADT in the background of our Sonar clinical apps, but the source of truth, where we would make changes, which was the-it wasn't view, it was to make changes is the proprietary system. That's why I thought this was important. Do you, in your testing procedures, even for the Sonar ADT module, have to show that you're able to update in the ADT system?

John Travis – Cerner Corp.

Yeah, I think that there's—you made a decision that was in part based on use. There is capability present, for example, in our system to do, for the, for the set of demographics that were part of stage 1, you can do those without necessarily using our ADT system. I think it is an operational question of if it's necessary.

There's certainly no constraint to say a vendor couldn't or shouldn't present those, um, for certification. I think the-the worry a vendor would have, and it just speaks to going about things in essentially different combinations on a modular level, is boxing people into that answer, because the-the thing that can ha-that happens so easily is you're certifying a particular combination. So the vendor presents their ADT system in their clinical EHR, you know, inpatient acute care EHR workflow solutions together. That's what's been certified together, you know.

So it makes statements about—because of the possession policy you've got to be careful what combinations you present. So perhaps it's that you present the ADT system as an EHR module and then you don't box people in if they have a different ADT system that's also certified, but it does assume a behavior in the market that we're all going to do that.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Right. I think what, Chris, I assume what you're going for here is obviously all these elements are required. We have to capture this data and we have to be able to show that a certified EHR data EHR can capture it and allow for modifications. Now obviously there—

Chris Brancato – Deloitte

… paragraph correct, because I'm still reacting to the Medicare card and the—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Well yeah, a-a-a-so let's try to get first test first paragraph. So I think, I think what we need to do is we just need to, you know, whether, again, we tried to describe a real life scenario, which is the task that we gave you.

The reality of it is what we're looking for from a testing criteria is that we're able to gather this information from whatever source, it could be a kiosk; it doesn't have to be on paper. And then we need to have it, information available because it becomes then part of our decision making, um, logic when we make decisions about care rendered to this patient based on some of the demographics for example. So I'm not, again, what we need to test for, and I don't know if this says it or not, can we capture and modify this information?

So here's a suggestion. So what we want to say in this scenario is that, you know, the, this information is going to be provided from a number of sources and we're able to view and modify it electronically, right? Wrong?

Chris Brancato – Deloitte

That would be re—this is Chris Brancato. That would be a requirement under the criteria.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Right. And so the scenario just needs to reflect that we got, that we actually get to that. Like John said, we need to go on to the next paragraph, but kind of keep in mind that the purpose of walking through this-this actual scenario with the vendor is to say, "At the end of the day that's what we actually have to do to meet the requirements."

And then I wasn—I, John you can speak. I have a, I have a comment about the two hospital bans, but you can speak about the identification cards and those kinds of things and how they play into this. We probably have the same comments.

John Travis – Cerner Corp.

Yeah, I—this is John again. I think that those work to be explicit requirements certainly for access management for the registration process. I don't—from what I know and I could be wrong, I don't think they fit within, um, use requirement. We're-we're crossing a little bit into the revenue cycle on those and I don't know that we have a need for insurance information anywhere. They're certainly valid for the admission process, but they are explicit.

They then would really cross a hard line and say, "If that's part of what the data capture requirement's going to be we would be certifying ATD systems, no question to do that." Versus saying you-it could be a demographic module that an EHR has as a core module within its scope as we do where, you know, you can do what I might term a clinical registration. It's to the implementer to determine if they view that as an authoritative source of truth as-as-as Liz pointed out. Um, but this would differentiate that kind of capability from my mind to be it's a full registration.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

So I think what we want to do, at least let me throw this out to the group and see if this is palatable. I think what we want to do is shorten the registration scenario. What we're looking for is a way to flow the-a directed mix. This is what we've chosen to do, and appropriately a direct admit versus an ED admit. That we just need to-to acknowledge that during the process of-of, you know, um, physically moving the patient from one area to another and whether it's, and because we also, frankly, don't—a lot of hospitals no longer send patients to registration and they admit them directly to a bed and we do the information there. So just, you now, just a sort of piece of information.

We do need to have a wager in this testing scenario to assure that the appropriate demographics are kept, and that's all, I think, we need to do. I don't think we need to get into the financial component of it. Um, and I-I was even sort of wasn't sure where the two hospital identification bands thing came from. Um, so Chris can you help me with that one?

Chris Brancato – Deloitte

Sure. Um, so where I was coming from on that is, um, … patient safety recommendations and, um, that's-that's where that came from.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Okay so we—you're-you're right from the perspective that we usually do use two forms of ID, of some variety, um, so that we're, you know, you know all the reasons. You've obviously gone back and done your research. So again, um, then we have to go back to the how far do we take these scenarios in terms of testing for the criterion that are required, but not forgetting that we want to have a safe environment.

John, um, you know, this does not say anything about the EHR. So we're not—we wouldn't be putting the-the-the person's approaching for certification in a testing problem. But again, it feels sort of out of scope for this testing scenario to contain this particular sort of process.

John Travis – Cerner Corp.

Yeah, there's a lot of description of things that are occurring outside the system, which I understand it makes the scenario read and flow as necessary, the transport stuff for example. And that, by the way, does have potential of its own automation capabilities, but those are outside of scope. Uh, you know, I think what—if we have that descriptive text in there, you know, maybe some way to delineate that it's, you know, an instruction or guidance point on the certification inspection that you're not—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

I mean, again, just like—I agree. It was slow and when I read it, and again, I think it does add to the flow. It's funny how the patient gets from some, from somewhere, um, to a hospital bed.

The other thing that I wanted to comment on is the way this is described, this-this scenario, it feels like it is strictly a direct admit from a physician's office and there are other kinds of direct admits, you know, that that was—I think if we can take out some of the specificity we will get to where we need to be. And the reason I say that to you is we get lots of admits from nursing homes, assistant living, home health, you know, "I called my office," "I called the doctor's office. They told me to come directly to the hospital," which is sort of where we, I think we've fixed that in the first part.

We're now saying, you know, maybe what we do for these two paragraphs, "Upon arrival of admission office and the admission office orders," maybe we just put a caveat, you know, over to the side, you know, what the purpose of this is just to flow the patient to the point where they're in a patient bed and begin to utilize the EHR, not necessarily for testing or something. You know, you can dress it up better than that, but I-I think that will make it easier and more palatable.

Chris Brancato – Deloitte

So-so it's Chris Brancato. A-a couple of comments, um, clearly the things that we're discussing here, um, kind of reside in the flaw of the general, um, assumption that this is a critical access hospital and the assumption here was the physician who referred to the hospital does not have admitting privileges. Um, so we can easily fix that, um, by just, you know, certainly reworking that section and, you know, clearly imply that the physician has the ability to direct admit and the privileges to do so.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Right, I mean, 'cause, and-and the scenario that you called out, Chris, in all fairness, would work for hospitals as well. It would just simply be a transfer of care, but, um as you rework this part of it, if you will just, um, you know, be sure to denote that wher-we're not expecting, as part of this testing scenario, that these activities that are listed in the paragraph that starts, "Upon arrival to admissions," or around financial information so on is not going to be captured nor is it required as a clinical EHR, the certified EHR.

Chris Brancato – Deloitte

Understood. And I-I-I think John raises a-a very important point. In balance to the flow of the scenario, recognizing that each individual functionality called out in the criteria will be certified on a modular level. Um, um, so I think the balance there is, um, how-how do I bring this-that information into the scenario without being redundant to the individual criterion testing script?

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

When you say that-when you say th—I'm sorry, Wes, and I'll let you speak—when you say that are you saying that those two paragraphs contain criterion that needs to be tested for?

Chris Brancato – Deloitte

No, no, in fact just the opposite. I-I'm not intentionally duplicating language from the test script for that particular functionality criteria.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Okay. Wes, did you have a comment?

Wes Rishel – Gartner, Inc.

Yes, I-in summary, w-what I hear is that in trying to create a-a meaningful context through the scenario we risk being perceived as adding-adding criteria. You know, for example to go to the patient safety rules and say, “Print two wrist bands,” or, “Print two bands,” depending on the size of the, of the person is-is um, could e-could be mistaken for our thinking that something-for someone thinking we’re going to certify the EHR despite no audit trail back to the Policy Committee saying that that was a criterion.

Um, um, and I think that the concern that, you know, people react somewhat defensively to these documents, I think the concern that we avoid that confusion is very strong to the point where we want any comments that represent context or a-a scenario that … but not a criteria to be in a different font or a different column or somehow so clearly called out that-that when people are working up a fine, frothy bit of rage they have to find something else to get mad about.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

I always love it, Wes. You know, it’s it’s-it’s always a treat. So I-I-I’m sure that Chris, you and-and Scott have the general sense of what we, how we’d like to see this next time we run through the next version of this, right?

Chris Brancato – Deloitte

Yeah, we can scale that back. Uh, that’s not a problem at all.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

So now we’re going to move into evaluation, diagnosis and treatment scenario, and I think, um, Joe had the same kind of response that I did. Um, either—on the referring physician comment, and I don’t know wha-if everybody’s got their electronic copy now, but what the—it kind of follows what we’ve already talked about, which is whether it’s the referring physician that now is the admitting physician or whether it’s the referring physician that is handing it over to an admitting physician. Some kind of comprehensive, um, dataset, you know, it was CCDA or some kind of summary with extractable data has come across and is available to the nurse so that she would be or he would be able to start their physical and, um, um, verbal evaluation of this patient at that time using that document. I think that’s what you were trying to get to.

M

Yes.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Okay. And then, Joe, you made a comment about dur-uh, referring to the … nursing assessment. Um, the note is more valuable than the CCR as it appears to imply the bulleted list. I think you’re saying the same thing we’ve been saying, which is it appears that all this information is available to the nurse on admission and it’s probably not. Is that right?

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

Yeah, I-I-I don’t remember the comment any more, but, um, but I think you’re right. It sounds like that anyway.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Right. So anyway, again, I think that from there it goes on to talk about the nursing assessment and obviously they would, um, would—the nurse would obviously access any information that wa-had been submitted and was available prior to doing the assessment just so that they go in with a-as much information already needing only to be verified not to be found on an initial discovery process, I think is what we said. Um—

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

I mean there-there has to be the ability to record a complete history and physical.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Absolutely.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

And I think I remember making a comment when I thought it was a clinical access hospital that the likelihood was that the admitting physician was the person who was making the transfer, and that therefore they would have already sent their complete history and physical or dictated one.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Right. And again, I think the truth of the matter is—and-and so, again, what we want to do is test for the availability to do, regardless of-of what comes to us or not, at the end of the day we want to make sure that we get a complete history and physical and set of, you know, um, smoking status and current meds and past meds and so on. At the end of the day we want to get it all done. I think we're just trying to take advantage.

And I did think your comment was also appropriate that, um, w-we don't generally have patients—this is about medication history—medication reconciliation is probably one of the toughest things we have to do, um, both for nursing and for physicians, although the physician, based on our current rules, is responsible for being the captain of the ship and, and finalizing that list. But I-I think that we can test using this scenario recognizing that where the information is coming from is still a number of sources, not quite as simple as not being in this scenario.

So I think it's back to Wes' comment. Some of this is just simply getting a-a workflow where we can test the number of elements all at one time instead of individually, if possible. Recognizing that the-the source of the data is going to be local to the specific institution. I think that's fair. John, you think—?

John Travis – Cerner Corp.

Yeah, I think that makes sense.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

So the—anybody have any other comments because I want to go down and talk about standing orders, but does anybody else have any other comments about the way we've described or the purpose of saying between the nursing assessment, whatever we get in the CCDA or whatever other summary, all together at the end of the day the EHR needs to capture all of this data?

And hearing none I'm going to move to the next paragraph. And my comment was, ah, we don't use standing order sets. Um, and-and it's a—so what … says is the nurse activates any standing order sets using CPOE or-and order entry functionality.

Now we do use protocols, um, and this is somewhat specific to my organization but I can tell you it's also a global issue. Um, it is very important to us as a physician, um, if they have a planned order set of some-in whatever form or fashion their vendor may allow them to do that, and then we can add to that, um, what-whatever you may call it, a protocol, a care set, but there are very strict rules around from, outside regulatory bodies about standing order sets. So we need to pick a different word. Does anybody have any idea what I'm talking about?

John Travis – Cerner Corp.

Yeah, I do. You get into condition of participation requirements and there're-there's very specific difference given the medial staff, bylaws about their use, how they're approved for use, how they're initiated.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Yeah, I mean, the scenario kind of infers that, um, that we have something sitting out there that we-we look at this history and we just sort of launch it. And what is true, so I want to be sure that we're clear with the folks on the workgroup, what is true is that there are very specific things that we are absolutely by all, by CMS, by joint, by everybody allowed to do, which is—first of all this is an emergent situation, which we're not talking about there, but even in non-emergence if there are things where we follow a set of orders that has been approved by a medical staff and we did the very same thing with every patient that comes in with the same problem, those are allowed, but that's different from what's here.

And I-I wasn't sure, um, I-I wasn't sure what you were trying to get to Chris. I was trying to figure out. You've got some admission data now. What normally would happen then we would be looking for a set of admission orders to act on.

John Travis – Cerner Corp.

That actually was-was my intent. Um, you know, every, every hospital in EHR we're going to—come to think of it we did call them protocols for a particular thing. In fact, some physicians have their own protocol.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

And we also have, and depending on the system that you're using and what you may call it, but there is the ability for a doctor to either enter orders remotely or enter planned orders, you know, based on something they know is coming. You sort of introduced this as a direct admit. So if a doctor has not entered any orders electronically, then really the next step is to contact the physician and to, um, ask them to enter orders via CPOE. Now understand, that's best life scenario. We still have patients walk in with written orders. We still get verbal orders.

Chris Brancato – Deloitte

We can rework that, no problem.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

And then the next thing is, um, here, um, you, um, on the next paragraph we talk about nurses entering medication orders. And, um, there's just a caveat. I'm not sure how to work it in here, but I want you to be aware of it, and that is-is that regardless, in most hospitals of who enters the order and obviously nurses are not licensed to enter medication orders but they could certainly enter it on behalf and have a co-signature. However, we do require first review by …, or in our case the pharmacy. Let's just say the pharmacy, and that's, that's not here. And I don't know, John if that, you know sometimes I mix what is, I know, required by so many other bodies versus what meaningful use would call for—

John Travis – Cerner Corp.

Yeah, there's-there's always been a tension point of crawling into the pharmacy departmental space. You know, I think it ends at the order communication, um, and, you know, even possibly with the physician order verification, but you're not getting to the pharmacist review prior to dispensing. There-you know, there's, there's a bit of a things are going to happen outside the context of the meaningful use testing that we know goes on.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Right, and I don't want to build it in here for the very same reasons we talked about before. I don't, you know, I want the scenario to be real life.

Chris Brancato – Deloitte

So, Liz uh, Chris again. That-that sequence of pharma-a pharmacist review is built into eMAR.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Yeah, yes it is, because the-the drug was—well the drug actually shows up on the eMAR as soon as the physician enters it, but it shows it as unverified.

John Travis – Cerner Corp.

Right, well, and I think you have some of the same issue with that that you do with CPOE that there are no questioned pharmacy activities for medication order review prior to dispensing and, you know, how the medication gets filled and delivered. By its very nature you're going to have to put a constraint on. I think one and two things may be true, and-and this just may be a statement for ONC to consider.

One is do you allow the vendor to go show some things extracurricular certification for the sake of the flow of it without taking the Julia Childs' approach and saying, "You know, I've got something that's already,"—for the sake of showing the literal boundaries and context of medication administration, I'm going to go in there and show you a scheduled med that's already been through whatever pharmacy processes need to occur. You're not seeing those in specter, but trust me, they happen.

And I'll start with the fact because what you're asking me to do for certification is to show the administration of the five rights, and, you know, the bedside activity that would occur with eMAR, um, and documentation and so forth, but not the pharmacy dispensing activities or going to the medication dispensing cabinet and doing all that. Um, or you say you can show me some things that are necessary for this to get to that state, but they'll have no consequence on your testing, in terms of the certification activity nor will they imply that they must have the-your same system.

Again, I get concerned when we get too encompassing because we then get into the case of, "Well gee, your system can only work with your own system." You know, you've got to have PharmNet to make PowerChart work for eMAR. Um, that's not entirely true. You could work through other mechanisms and-and obviously there are even processes that can start out with them being manual, um, to get into the automation, if you will, if they're not interfaced or integrated.

So we've got to be careful about what we say to the-to the—I'm thinking of the-the inspector sitting there with a set of instructions about where they apply their judgment as to pass/fail of the certification testing versus, "Okay, I see that that's just kind of surrounding setup you need to do in order to show me this." You're not prejudicing your certification on it to say you've got to have that vendor's pharmacy system to make this work.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Right. So what we probably ought to do is we probably ought to say the nurse activates, um, admission orders and just let it go at that. Um, and then when we get to the medications my recommendation would be, to the workgroup would be to say let's don't get into the pharmacy part of it, John, for now, and-and knowing that we have other people that are coming to see us besides meaningful use auditors.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

This is Joe. Um, when-when it's time I want to talk about the next paragraph, which talks-starts with, "The physician arrives."

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Alright, let's go there.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

Alright. I-I-I think what I would say there is, "The physician arrives shortly to see the patient. Reviews the information from both the nurse and the referring physician and completes a medical history."

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

That sounds good. That's realistic.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

Exactly. I mean he's not going to take that information and then just stick it in the chart, I hope.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

No. And-and nor would the nurse.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

Right. And-and then the next part where it says, “After review,” I would take out “after review” and I would say, “The physician performs a physical examination and records it in the medical record.”

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Right. And that way—now, as long as, um, Chris and Scott, we’re clear that we are not—you notice that Joe did not say, “Record electronically.” He just said record. Eventually it will be recorded electronically, but that’s not currently a requirement.

Chris Brancato – Deloitte

Understood.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Okay. And the next-the next place that we’re going to is the clinical note. And, you know, um, Joe pointed out that it might be, um, it might be a clinical note from an office that came over or got faxed. But the other thing I was going to say to you again is you said, “Enters his clinical note into the EHR,” and my recollection was that the-their-tha-back to Wes’ comments earlier, we really—now we don’t know what’s going to come out—but we really loosened up that initial, um, request that came from the policy committee, um, and actually it got loosened more than we anticipate, at least for me, when the stage 2 proposed rules came out. So I wasn’t sure if you thou-Chris, were preparing for entry of—what you, what you were thinking. I mean, le-let me not put words in your mouth.

Wes Rishel – Gartner, Inc.

Let me just make a suggestion about that entire paragraph so that Chris can mend comments on that suggestion as well. And that is I would say knowing that we’ve already recorded the history and we’ve recorded the physical, because that was the changes in the previous paragraph, I would say, “Once completed, the physician selects the national clinical guideline for diabetes and performs the following.” Instead of all that stuff in there about entering things in clinical notes, activating a clinical decision support functionality—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Yeah, we know where you’re going, Chris. We know what you’re going after, because it is required that we do clinical decisions … and it’s required that we used evidence-based, but I agree with him. I was going to make one more suggestion. So we’ll just keep piling on.

I realize we wrote this about diabetes, but I have a question about that. And that is, does that then, um, I’ll just use the word box the vendor into having show a national guideline for diabetes, or because what I wrote to myself is can we create a useable test standard with some leeway without creating a scenario that the vendor then has to test for every national guideline known to man?

Because what I thought was I understand why we do this. So the patient came in with diabetes. We stuck with that theme. I get it. But my concern was, um, you know, would—is it rational that every EHR—we didn’t call that diabetes, at least not to my knowledge. It certainly, it’s a good choice but is it the only choice? And, John, you speak to that too. Again, you’re the one who has to go through this testing business.

John Travis – Cerner Corp.

Yeah, no, I don’t know that it’s the only choice. Um—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Or is it one that’s—I mean we have to pick—

John Travis – Cerner Corp.

It’s certainly valid, and, you know, it-it might be one the vendor picked, but if you’re suggesting that perhaps you say something of the nature that, you know, the physician—that we’re just implying there’s a chronic disease—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Exactly. That's what—all I was saying—what I was thinking in my head when I was r-reading all this was thinking, "Is there a way to build in the fact that it would be appropriate to have a national guideline for the disease process that we're teaching- or that we're treating, or that we're testing for in this scenario?"

And I'm not objecting to diabetes. I just-I don't think it's specifically called for in the rules. Um, it may be, but I don't think it is, and so I was looking for something that would add some leeway here without opening up Pandora's box, which is now a vendor is suddenly supposed to attest for every client disease known to man. And, Chris, if you guys want to just think about that. I-I, again, I do clearly understand why you picked diabetes because it goes with the scenario.

Chris Brancato – Deloitte

No, and, I, this is a fabulous bit of feedback for the office as we consider, you know, exactly what the construct of this looks like. Um, so, you know, thank you for that. That-that's incredible feedback.

John Travis – Cerner Corp.

I will—this is John. I will say and I think about other things, you know, ironically there may be a constraint coming back anyway through the use of a test dataset. So it may not be as simple as vendor choice … how we test it for syndromic surveillance in 2011 certification. We were—we did get latitude there, but in other cases, like for laboratory data, they gave us explicit datasets to use and really there was nothing wrong with that and the vendor did have to prepare something to support that. Um, so there were—we are used to not having latitude. I'll put it that way.

And the test dataset might compel you to in fact pick a national guideline for a specific disease state and, you know, even if we don't say it here it might be said there, 'cause that's just reality. You know, they might define alternative datasets to say one is based on diabetes. One is based on COPD and one is based on—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

—or sepsis or stroke—I mean these are all—I mean, so Chris if you want to hear from us that we are not objecting to the disease process itself. We're just saying, just to ask you to examine the intent.

The next set of paragraphs, I would've—I think this is a sort of a combination of med reconciliation, um, I-I wasn't quite sure where we were on this one. You just continue—sort of like the process we just continue, we've adjusted the route and we're establishing new. To me, that's a description of med reconciliation.

M

Yes.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Okay. So, um, and then I—so I would expect a test to be able to show that that capability is just within the EHR. And then on the, um, eMAR checks, and then we'll stop for a second to see if others have comments on this part of it, um, you've looked at allergy and making sure, um, that the med was, you know was ordered, essentially.

You've done interaction with drugs. You also need to do drug/food. I think that is—if I recall correctly, those were listed but I could be mistaken. Then you've looked at dose and route and then currently formulary. Um, I did—the only one I didn't know about, we certainly do this, but I didn't know if that was formulary adherence was required in the reg or if it's just common practice. John, do you know?

John Travis – Cerner Corp.

I-I think the only case of it was that you had to show that there was a formulary that was accessible, um, and it-and it was stated that it'd, you know, it'd be good if that were the one relevant to the patient, but it didn't have to be. It could be an internal formulary as well.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

So this would test that. Did you—did Joe or John or Wes or, um, did you see anything else, um, Anne, anything else that was missing from this list as far as automatic checks?

John Travis – Cerner Corp.

I-I did and I'm actually going to back up to the laboratory piece. This is another place where kind of like with the pharmacy dispensing we might be wandering into, um, waters that are not within the bounds of the certification testing because we're describing a lot of activities that are occurring in the lab. Um, so—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Oh, oh, I see what you're—I know where you're going.

John Travis – Cerner Corp.

The laboratory—we do have laboratory—now there's no reas—nothing to say that a, you know, a-a-and we've had people raise this all the time, "Why don't you get your LIS certified in stage 1?" Well, honestly, the test was to incorporate structured live date into the EHR not for the LIS to produce it. And we do have a certification criteria proposed for doing laboratory test result distribution or reporting or dissemination to ambulatory care providers, and so we may well be presenting it anyway, but just on the grounds of this you're raising a lot of things that are done in the LIS.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

So which one are you looking at there?

John Travis – Cerner Corp.

The, through the EHR, the laboratory technician receives the order, which is usually going to be a function of the LIS for an inbound work list or, um—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Oh, you're on the next page.

John Travis – Cerner Corp.

Oh, did I go too far?

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

You did Yeah, that's—

John Travis – Cerner Corp.

I was thinking you were getting into talking about—I'm sorry.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Okay, we'll go to the next—

John Travis – Cerner Corp.

I'll hold my comments.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Okay, so anything else on the texts or alerts under EHR automatically checks?

M

I don't see anything but, and I don't know if I made a comment previously.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

No, I don't see anything from you. What I was going to ask is, um, you say Chris, it reads here, "Orders a panel of laboratory tests." I-I would just say, "Orders lab tests." I don't—there's a lot of reasons why I would say that to you. Just take it—take an order lab test; that's sufficient.

Um, when it says, “Order several tests to be performed by the radiology department,” I’m not sure if we have to do several or if one would be sufficient. I think what you’re looking for is connectivity. The idea is, frankly, in my head when I think about what—going back to the EHR—the radiology has to be there so we can result against it. That’s the only reason this would even apply at all, in my head.

A con-a consult, I had the same thing there, is, “Order a consult from an appropriate specialist.” Again, if you-if you write the dataset where it’s an endocrinologist, that’s fine. All you’re trying to look for is can the system, you know, refer to an appropriate practitioner, and then enters dietary activities daily.

Again, I—the only thing I would say for-on behalf of-of John and all his cor-uh, you know, constituents is any time we do things that are wide open like activities of daily living is undefined, that could be pretty rough. I assume that-that you have—we’d provide them what it was that you consider activities of daily living because it’s not qui-it’s not it’s not specified here.

John Travis – Cerner Corp.

Yeah, ‘cause you’ll be constructing an assessment form or something of that nature—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Right. Something so they can actually do it. And then, um, again, then we get to page nine which is the last page. Um, patient, you know assesses the EHR, reviews or acts upon them, documents, um, and I think that’s all fine. I’ve wrote it out to the side pharmacy first view, but we’ve already really talked about that. And then you wanted to talk about laboratory technician.

John Travis – Cerner Corp.

Yeah, yep, that second paragraph at the top of that page, um, is all descriptive of things to me that would occur in the LIS, and, you know, you even say that. Um, you know, so someone interpreting that, again, we have the-we have the question—we’re, we’re actually more plainly saying it here than we did in the pharmacy, um, you know, role towards eMAR and CPOE for medication orders.

Um, we’re actually calling out the LIS here. So it’s going to raise a question, quite obviously, for any vendor going, “Well I don’t have an LIS.” You know, so any vendor who’s not also an LIS vendor might look at this and go, “I’m not sure that I can test for this.”

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Right. So he just, again just like we talked about before, folks, we could just put something just to make the scenario flow, but it’s not a testable component.

Under Medica—did anybody else have any comments up to that point? Wes or Anne or—

John Travis – Cerner Corp.

One last little comment on the LIS, Liz, if I may—this is John. The terms “import” and “export” are kind of not the ones I would use. I think that you’re either in reality dealing with interfaces or integration. You’re not doing import and export. So I wouldn’t use those terms in any sense in terms of whatever you chose to do with that please don’t use those terms.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Anne, did you have something?

Anne Castro – Blue Cross Blue Shield of South Carolina – Chief Design Architect

No. I was saying no comment. Thanks.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

You bet. On the medication portion it says, “Arrive.” You’ve got identify the patient, identify the med, match the med to the order. I assume that’s where you’re catching time? When you think about the five rights it’s the right time to give its med. You might specify that. Um, dose matches, route matches and that’s the best we can do.

I mean ‘cause we can-we can only match the-the order, but we can’t, uh—the reason I say that to you is when you say verify the route administration matches the order. The computer can’t actually do that. If I decide to give something, um, have somebody swallow a pill when it’s really supposed to be done sublingually, which means under the tongue, the computer doesn’t know what I did.

So you want to match that the route of the drug that showed up is appropriate to the order so you didn’t get an oral tablet when you’re supposed to be hanging an IV bag, and I think that’s what you’re trying to say.

John Travis – Cerner Corp.

Yes.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Okay. And then like you say in the second bullet I would just make sure that we call out time. That’s a pretty important, um, right.

Um, and then I didn’t have anything else until we got to discharge. Did anybody else? Joe or John or—

John Travis – Cerner Corp.

No. ….

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

On discharge I, again, I, what I didn’t see here necessarily was med reconciliation at discharge, and I don’t know if—if you think about what the rules say, it’s really not it-it you have to do it—you don’t have to do it unit to unit so that’s good. We do. We do inside the hospital, but meaningful use does not call for that, but it does call for reconciliation prior to transfer to another, um, level of care. And that’s not called out here but we may have tested it previously. So John or whomever, I would defer that to you.

John Travis – Cerner Corp.

Yeah, I-I think that that is okay. Um—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

I mean we did hit educational, um, discharge and st—oh, that was the other thing. We talked about educational materials but we didn’t really talk about discharge instructions and they’re not necessarily one in the same.

John Travis – Cerner Corp.

No, and, you know, now that I look at it there’s also opportunity for a patient electronic copy … and if you want to, communication of lab results to the EP. So now that I’ve said something about don’t include the LIS here I could say—I could easily see you could construct that. Given that somebody might present that as modular, I’m not sure if we want to do that or if that really fits the scenario, but it certainly could.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Yeah, but again I think what we said all along, if you’re doing modular certification and you only want to be the-the-the piece of the—

John Travis – Cerner Corp.

That’s true. You just go do that you’re not doing the script, or the scenario. Yes, so I think you could put in something, assuming that stays in the final rule, that you could communicate the lab results, because you have performed them. You did do them. Um, you discreetly generate those.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

So, wow amazingly we’re like four minutes ahead of schedule and, um, we’ve actually gotten through the whole scenario. So I’d like to stop for a minute and say kind of general feedback overall have we missed something completely?

Chris, really good job. Um, I think, you know, for us to—I think we've, um, really captured a lot of information, a lot-a way of l-looking at a patient in a much more holistic way. Um, so you and Scott both, this is very, very good.

Chris Brancato – Deloitte

Thank you.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Joe or John, Wes, Anne, is there something that anybody can think of that we just flat—and again, I think we'll review against the final regs, obviously but that we just flat have not touched on in inpatient scenario that's related to meaningful use?

M

No. I think it's-it's a good body of work and I hope nothing of anything we've said, and I think you said it too—

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

This is Joe. I just want to go back to something that we've said earlier because I think there might be a misunderstanding. When a physician has admitting privileges that means that they can admit the patient and take care of the patient within the hospital. Well there was some mention there that, about direct admits that the physician had admitting privileges, but the scenario is about a physician who doesn't have admitting privileges or at least doesn't exercise them.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

So it-would it be more sensible, Joe, just—

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

….

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

The ad-the ref-the physician in this scenario is one that has a practice outside of the hospital but also has admitting privileges to the hospital.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

No, because the physician—if the physician had admitting privileges to the hospital, the physician would admit the patient and take care of the patient.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

And you think this infers that the patient was referred and somebody else took care of them.

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

Exactly.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

I gotcha. Is that a problem as long as it's clear?

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

As long as it's clear—I just think the implication of, I mean I wish it were so that physicians still admitted their patients and took care of them, but it doesn't happen very much anymore.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

No, it's-it's definitely a trend that's changing. So, um, Chris and Scott, I think you're clear right? We'll make sure that it's clear as we read through these scenarios for the last time in the next meeting.

The work ahead of us will be the emergency room, um, certification. And we all have it now and so I think we have a meeting in about a week. Is that right, MacKenzie?

MacKenzie Robertson – Office of the National Coordinator

I'm checking now. Hold on a sec.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

I think it's—I want to say its maybe-maybe it's two weeks. I don't know.

MacKenzie Robertson – Office of the National Coordinator

You have one on Monday the 13th.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Oh, Monday like in five-four days?

MacKenzie Robertson – Office of the National Coordinator

Yes.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Um—

MacKenzie Robertson – Office of the National Coordinator

At 9:00 a.m.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Well, let me quick—and then don't we have another one like on the 23rd? Is that right?

MacKenzie Robertson – Office of the National Coordinator

Yeah, the 23rd.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Okay, let me query the group. We-we-we've kind of got this down to, um, you know, somewhat of an, you know, a pretty easy way to go through it. We have two choices in my mind, but I'm asking the group for their input.

We could not have our meeting next Monday and-and, um, wait for the 23rd and give people a chance to read the emergency room or we could just get through the emergency next Monday and I-I think we'll—we've sort of got a rhythm down and then use the meeting on the 23rd to be more into a review mode. What is the-what is the sense of the committee, the workgroup?

I'll just tally you individually. Wes, what do you want to do? He may have had to drop off. Uh, John?

John Travis – Cerner Corp.

I think, you know, we can go through it fairly interactively, uh—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

On the 13th?

John Travis – Cerner Corp.

That'd be my—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Okay. Joe?

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board

Um, I'm-I'm sort of neutral. Either way is okay with me, I believe.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics
Okay. Uh, Anne, do you have a preference?

Joe Heyman – Optum InSight – Chair, National Physician Advisory Board
I'm free so it makes no difference to me.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics
Okay.

Anne Castro – Blue Cross Blue Shield of South Carolina – Chief Design Architect
I wasn't scheduled for the 13th. I don't know if I blew it away or—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics
Yeah, I need to look too. I thought I-I-I-m hoping I didn't blow it away.

Chris Brancato – Deloitte
I have it in my calendar.

John Travis – Cerner Corp.
It's on mine as well.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics
It is on mine as well.

Anne Castro – Blue Cross Blue Shield of South Carolina – Chief Design Architect
Okay, so I must've done something. I'm unavailable on the 13th, but I'm not a key player so, you know, I support whatever your decision is.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics
Okay. Well we'll go ahead—MacKenzie, we'll go ahead and meet on the 13th and see if we can't get through the ED. And that gives us more time to sort of make sure we've got everything polished up and ready to go.

Anne Castro – Blue Cross Blue Shield of South Carolina – Chief Design Architect
Okay, and I won't be available, but—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics
Okay. And then, and you'll be able to join us again. I think the next is on the 23rd.

Anne Castro – Blue Cross Blue Shield of South Carolina – Chief Design Architect
Yeah, I've got that one.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics
Okay. So you would be available to kind of join us back at that time and-and make sure we stay on track.

Anne Castro – Blue Cross Blue Shield of South Carolina – Chief Design Architect
Correct.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics
Okay.

MacKenzie Robertson – Office of the National Coordinator
And so, Liz, this is MacKenzie. Just to recap, in terms of next week for the-the letter that you're going to be presenting to the Standards Committee, how much time do you anticipate needing on the agenda for that?

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

In September?

MacKenzie Robertson – Office of the National Coordinator

Oh, sorry, we're not going to do it on the 15th?

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

No.

MacKenzie Robertson – Office of the National Coordinator

No?

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

No. We're going to—oh the letter, I beg your pardon. Mary Joe inquired me while you were gone. I-I said about 20 minutes max. Everybody will have read it. We're just looking for input. You usually do 30-minute increments. That's fine.

MacKenzie Robertson – Office of the National Coordinator

Okay. And that'll just be the letter, not—

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

That's all we're doing. We're not-we're not going to give an update on this. So can we go to public comment?

MacKenzie Robertson – Office of the National Coordinator

Sure. Operator, can you please open the line for public comment?

Operator

(Instructions given.) We do not have any comment at this time.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

Okay, great. Thank you, everybody, for, um, all of your input and we look forward to talking to you Monday.

MacKenzie Robertson – Office of the National Coordinator

Thanks, everybody.

Elizabeth Johnson – Tenet Healthcare – Vice President, Applied Clinical Informatics

All right, bye now.

Public Comment Received During the Meeting

The ASTM has a Social History section which support all tobacco history elements. I believe this is also part of the CCD. Although not part of C32.